Washington State Health Care Authority
Public Employees Benefits Board

2012 COBRA Continuation or Extension of Coverage

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- List eligible family members you wish to cover or disenroll.
- If enrolling a dependent with a disability age 26 or older, or an extended dependent, you must attach the appropriate dependent certification form. Forms are available at **www.pebb.hca.wa.gov** or by calling 1-800-200-1004.

Employee or Retiree Information ONLY	Employee/retiree name	
	Employee/retiree social security number	Date employer coverage ended (mm/dd/yyyy)

Are you making changes to an existing account? ❑ **Yes** ❑ **No** *If no, go to Section 1.*

If yes, what changes? *(Check all that apply in the sections below.)*

Changes you can make anytime *Give date of event/change* _____

❑ Name change
❑ Address change
❑ Disenroll from medical coverage
❑ Disenroll from dental coverage
❑ Disenroll dependent(s). If disenrolling due to loss of eligibility (divorce, legal separation documented by a court order, dissolution of domestic partnership, death, or other loss of eligibility under PEBB rules), y**ou must submit this form no later than 60 days after the event.** If applicable, provide dependent's new address:

_____

Additional changes you can make during annual open enrollment *All changes become effective January 1 of the following year.*

Check the box(es) next to the change requested.

❑ Add dependent(s) ❑ Change medical plan ❑ Change dental plan

Additional changes you can make if a qualifying event occurs (special open enrollment)

The PEBB Program will only allow changes outside of an annual open enrollment when allowed under PEBB rules (see WACs 182-12-262 and 182-08-198). You must submit this form **no later than 60 days** after the event. However, if adding a newborn or newly adopted child, and adding the child increases your premium, you must submit this form no later than 12 months after the birth or adoption. You must provide proof of the event that created the special open enrollment.

Check the box(es) next to the change requested, and indicate the event(s) below. *Give date of event* _____

❑ Add dependent(s) ❑ Change medical plan ❑ Change dental plan ❑ Other—explain: _____

- ❑ New spouse, Washington State-registered domestic partner, or child added to family due to marriage, Washington State-registered domestic partnership, birth, adoption, court order, or medical support order.
- ❑ Child becoming eligible as an extended dependent through legal custody or legal guardianship. *Also complete* Extended Dependent Certification *form. Form available at* **www.pebb.hca.wa.gov**.
- ❑ Child becoming eligible as a dependent with a disability. *Also complete* Certification of Dependents With Disabilities *form. Form available at* **www.pebb.hca.wa.gov**.
- ❑ Dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ❑ Dependent having a change in employment status that affects the dependent's eligibility for the employer contribution toward group health coverage.
- ❑ Dependent becoming eligible or losing eligibility for premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).

The following events also allow a health plan change:

- ❑ Subscriber or dependent having a change in residence that affects health plan availability.
- ❑ Subscriber or dependent becomes entitled to Medicare, or enrolls in or disenrolls from a Medicare Part D plan.
- ❑ Subscriber or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA).

Are you or any eligible dependents enrolled in PEBB coverage under another account? ❑ **Yes** ❑ **No**

(continued)

2012 COBRA Continuation or Extension of Coverage *(continued)*

Subscriber's last name	First name	Middle initial	Social security number

Section 1: Subscriber Information (COBRA Enrollee)

Social security number	Last name	First name	Middle initial	Sex
				❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code

Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number (including area code)	Home phone number (including area code)
		( )	( )

Select coverage you wish to continue: ❑ Medical and dental ❑ Medical only ❑ Dental only

If you have optional life insurance and wish to continue it, complete and submit the *Group Life Portability Application* no later than **31 days** after your coverage ends.

❑ **Disenroll** **Reason** _____ **Disenrollment date** _____

Are you covered by another group medical plan? ❑ Yes ❑ No If yes, effective date _____

Are you covered by another group dental plan? ❑ Yes ❑ No If yes, effective date _____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____

If yes, you must send a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Are you enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No If yes, effective date _____

Part B (medical) ❑ Yes ❑ No If yes, effective date _____

If you are enrolled in Medicare Part(s) A and/or B, attach a copy of your Medicare card to this form.

Section 2: Spouse or Qualified/Washington State-Registered Domestic Partner Information

List eligible family members you wish to cover or disenroll. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.

Relationship to subscriber:

If adding a Washington State-registered domestic partner, please complete and attach a *Declaration of Tax Status* form.

❑ **Spouse:** date of marriage_____ ❑ **Domestic partner:** date qualified or registered _____

Social security number	Last name	First name	Middle initial	Sex	Date of birth (mm/dd/yyyy)
				❑ M ❑ F	

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

Select coverage to continue: ❑ Medical and dental ❑ Medical only ❑ Dental only

❑ **Disenroll** **Reason** _____ **Date of event** _____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date _____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date _____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____

If yes, you must send a copy of the Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No If yes, effective date _____

Part B (medical) ❑ Yes ❑ No If yes, effective date _____

If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card to this form.

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2012 COBRA Continuation or Extension of Coverage *(continued)*

Subscriber's last name	First name	Middle initial	Social security number

Section 3: Family Member Information (such as child, etc.) *Use additional forms for more members.*

List eligible family members you wish to cover or disenroll. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. If adding a child of your qualified/Washington State-registered domestic partner, attach a Declaration of Tax Status *form. Also attach appropriate certification form(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent.*

A	Relationship to subscriber	Social security number	Disabled? *(Check only if age 26 or older.)* ❑ Yes ❑ No	Sex ❑ M ❑ F

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

Select coverage to continue: ❑ Medical and dental ❑ Medical only ❑ Dental only

❑ **Disenroll** **Reason** _____ **Date of event** _____

Covered by another group medical plan? ❑ Yes ❑ No If yes, effective date _____

Covered by another group dental plan? ❑ Yes ❑ No If yes, effective date _____

Disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____

Disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No If yes, effective date _____

If yes, you must send a copy of the Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) ❑ Yes ❑ No If yes, effective date _____

Part B (medical) ❑ Yes ❑ No If yes, effective date _____

If enrolled in Medicare Part(s) A and/or B, attach a copy of the Medicare card to this form.

Section 4: Medical Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative [1]
- ❑ Group Health Classic
- ❑ Group Health Consumer-Directed Health Plan [2]
- ❑ Group Health Medicare Plan [3]
- ❑ Group Health Value

Kaiser Foundation Health Plan of the Northwest [1]
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan [2]

❑ Medicare Supplement Plan F, administered by Premera Blue Cross [4]

Uniform Medical Plan, administered by Regence BlueShield of Washington
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan [2]

[1] **These plans offer Medicare Advantage plans to Medicare enrollees in certain counties. Complete and attach the *Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available.**

[2] **These plans are available only to retirees not enrolled in Medicare. If you cover a dependent enrolled in Medicare you must cancel your dependent's PEBB coverage before you can enroll in this plan.**

[3] **If you cover family members not enrolled in Medicare, also check Group Health Classic or Group Health Value for your family members' non-Medicare coverage.**

[4] **Complete and return form B to enroll in Medicare Supplement Plan F.**

Section 5: Dental Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Preferred Provider Organization

❑ Uniform Dental Plan, administered by Washington Dental Service (Group #3000) (may receive services from any provider)

Managed-Care Plans

❑ DeltaCare, administered by Washington Dental Service (Group #3100)

Dentist name or clinic code _____

(must receive services from a DeltaCare provider)

❑ Willamette Dental of Washington, Inc.

Clinic location _____

(must receive services from a Willamette Dental Group provider)

Please sign and date this form on the next page.

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2012 COBRA Continuation or Extension of Coverage *(continued)*

Subscriber's last name	First name	Middle initial	Social security number

Section 6: Signature *Required*

I have received and read the *Continuation of Coverage Election Notice* including any appendices. By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If we do not qualify, I will receive a refund.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

This form replaces all *COBRA Continuation or Extension of Coverage* forms previously submitted to PEBB.

HCA's Privacy Notice:
We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-923-2822 (effective January 1, 2012, call 360-725-0442) or go to **www.hca.wa.gov.**

Subscriber's signature _____ **Date** _____

Please sign and date this form.

Return to:
Washington State Health Care Authority,
P.O. Box 42684, Olympia, WA 98504-2684

If payment is enclosed, return to:
Washington State Health Care Authority,
P.O. Box 42695, Olympia, WA 98504-2695

2012 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233 **1-888-901-4636 or TTY 1-800-833-6388**

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099 **1-800-813-2000 or TTY 1-800-735-2900**

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327 **1-800-817-3049 or TTY 1-800-842-5357**

Uniform Medical Plan, administered by Regence BlueShield of Washington, P.O. Box 91015, MS BU248, Seattle, WA 98111-9115 **1-888-849-3681 or TTY 711**

2012 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157 **1-800-650-1583**

Uniform Dental Plan, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157 **1-800-537-3406**

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611 **1-855-433-6825**